



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



STATEMENT

Jay E. Berkelhamer, MD, FAAP

President

of the

**AMERICAN ACADEMY OF PEDIATRICS**

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Covering the Uninsured Through the Eyes of a Child

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The Homer Building

601 Thirteenth Street, N.W.

Suite 400 North

Washington, D.C. 20005

202/347-8600 • 800/336-5475 • FAX: 202/393-6137

The American Academy of Pediatrics (the Academy) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply committed to protecting the health of children, adolescents and young adults receiving health care in the United States.

The Academy is pleased to provide comments about the future of the State Children's Health Insurance Program, (SCHIP), a program which has been a resounding success. SCHIP also has had positive spillover effects on the Medicaid program. As a result of SCHIP outreach, millions of potentially eligible but uninsured children have been enrolled in Medicaid. Eligibility determination processes have been simplified, and coordination between SCHIP and Medicaid has become increasingly effective.

Despite the program's widely acknowledged success and popularity, several outstanding challenges have been identified by participating pediatricians. These challenges pertain to (1) Payment and Funding; (2) Ease of Enrollment; (3) Benefits available under the program. Recommended strategies in each of these three areas are outlined below. If these changes to the program are incorporated into this year's reauthorization, SCHIP's success will continue through its next decade.

### **Funding**

The SCHIP program is a block grant, which creates inherent difficulties. Because funding is capped, children have been denied services, waiting lists have developed and predictability in care is compromised. If it is not feasible to convert the program to an entitlement such as Medicaid, Congress should set the budget baseline for SCHIP at a rate significantly higher than the level set in law for the final year of SCHIP's initial authorization to avoid future budget shortfalls. Congress must also provide enough funding so that states are not encouraged to limit enrollment or benefits. Congress should strengthen its commitment to the federal-state partnership that has led to SCHIP and Medicaid's success over the past decade. With \$60 billion in new SCHIP and Medicaid funding over five years, states will be able to maintain their existing SCHIP programs, and avoid the tragedy of children losing health care coverage because the federal government did not maintain the commitment made in 1997 when SCHIP was created. This level of funding also will allow the country to move forward by enrolling most of the uninsured children already eligible for Medicaid and SCHIP and providing support to those states seeking to further expand coverage for children.

### **Payment**

One of the important problems with both the Medicaid and SCHIP programs is the rate of payment under each. On average, Medicaid reimburses pediatricians at only 69% of the rate that would be paid under Medicare, and only 56% of commercial rates for an office visit. In some states, Medicaid payment is even lower. While payment rates under Medicaid have been monitored by the Academy, the SCHIP program makes it much more difficult to deduce rates of payment because some states have tied SCHIP payment to Medicaid while others have not.

Low rates of payment seriously impede access to quality health care for children. While a

number of states have taken steps to increase Medicaid and SCHIP payment rates to match those of Medicare, most have not. Low Medicaid and SCHIP payments do not cover costs, and increasingly force pediatricians to make difficult business decisions of continuing to treat patients at a financial loss, or limiting their participation in the Medicaid program altogether. The resulting lack of access for patients may then drive them to seek emergency room care that is significantly more expensive.

To address this problem, the Academy recommends that payment rates for pediatric services be set at least at 100% of Medicare rates. The risk of Medicare is that some states have low pay even under the system, but in general, Medicare payments are much higher than Medicaid and what can be discerned of SCHIP rates. Additionally, adequate payment must be ensured when new vaccines and other new technologies are introduced. Under capitated arrangements, states should ensure that provisions are made to reimburse physicians for the cost of the new vaccines until new contracts are negotiated. In addition, physicians should receive payment for the expenses associated with the administration of each vaccine. Congress should also adopt financial incentives for medical homes, especially in the care of children with special needs, including chronic care management, child and family education, and coordination and consultation with pediatric specialists and other support services. Recognizing the dearth of pediatric subspecialists nationwide, Congress should encourage the inclusion of pediatric subspecialists and the academic medical centers where they practice in managed care plan networks, and encourage coordination and communication between pediatric subspecialists and primary care practitioners. Congress should also identify new mechanisms to designate and support safety net providers, including office-based pediatric practices and hospitals specializing in the care of children, who serve a certain proportion of publicly insured children. Finally, Congress should ensure that financing structures encourage medical home and pediatric subspecialty network continuity in SCHIP and Medicaid when children switch managed care plans and when children switch between the two sources of coverage.

### **Extending Eligibility and Enrollment**

Beyond payment rates, it is also important to raise the issue of enrollment barriers. The evolution of the SCHIP program has spurred the Medicaid program to encourage enrollment. Nevertheless, passage and implementation of the Deficit Reduction Act (DRA) took this success in the wrong direction by erecting virtual barriers to access. One of the most significant changes brought about by the DRA was the requirement that enrollees document citizenship and identity. After a harsh interpretation by the Centers for Medicare and Medicaid Services, a bad law was made worse. We are starting to see the results. As one example, in Georgia, it has been documented that over 100,000 children have been cut from the rolls after the implementation of the regulations called for by the DRA. These children are not illegal, but are citizens in poor families who are simply unable to meet the stringent documentary burden required by the CMS implementation of the DRA. This state of affairs is unacceptable and must be reversed.

Congress should also take the following steps specific to the SCHIP program during reauthorization. Congress should establish a performance-based outreach fund to encourage enrollment of all uninsured children who are eligible for public coverage. Administrative simplification should also be improved upon so that enrollment and reenrollment can reach the

most possible children. States should be encouraged to adopt shortened forms, streamlined verification requirements, online enrollment, and renewal assistance. In addition, states should receive the authority to automatically enroll children into SCHIP (and Medicaid) on the basis of findings of other means-tested programs, such as the National School Lunch Program or the Food Stamp Program. Similarly, presumptive eligibility should be encouraged for all children, allowing health care professionals and designated agencies to grant eligibility for up to 60 days while a child goes through the enrollment process. Additionally, states should be encouraged to adopt 12-month continuous eligibility for SCHIP-enrolled (and Medicaid-enrolled) children.

Beyond these steps, households with children in both Medicaid and SCHIP should be allowed to enroll in the program with the best coverage to ensure continuity among siblings with their pediatric medical home. SCHIP should also be expanded to include adolescents 19 through 21 years of age and allow emancipated minors to be eligible for SCHIP on the basis of their own income. In addition, eligibility restrictions for dependents of state employees should be eliminated if they qualify on the basis of income. Higher income families (>200% of the FPL) should also become eligible for the benefit where they are currently not eligible and asset testing should be discontinued to extend eligibility to more uninsured children.

To provide better services to children, SCHIP programs should not be barred from providing buy-in options for children whose family incomes are above their state's SCHIP eligibility level but who do not have access to or cannot afford comprehensive private health insurance. States should also be granted the authority to cover legal immigrant children. Finally, the program should allow states to draw down Medicaid/SCHIP matching funds when employers pay for a share of the cost of coverage for children enrolled in Medicaid or SCHIP.

### **Benefits**

The interplay between benefits for SCHIP and Medicaid populations should also be addressed by Congress in this year's reauthorization. Specifically, churning between the programs, into private insurance, and back again has become a documented reality for children throughout the United States as their family's economic situations change. It makes no sense from a clinical viewpoint for children in states without Medicaid expansion programs to be denied services guaranteed under Medicaid when they enter the SCHIP program. The need for vision, dental and mental health services does not disappear with changing economic circumstances.

Thus, the Academy recommends that Medicaid benefit coverage in states with Medicaid SCHIP programs must be preserved. Additionally, states should be encouraged to adopt SCHIP benefit packages that are consistent with the AAP policy statement "Scope of Health Care Benefits for Children From Birth Through Age 21," including dental services and the full range of mental health services, including substance abuse treatment. Preventive care, immunization standards, and periodicity schedules also should be consistent with current AAP requirements. Eligibility for the Vaccines for Children Program should also be extended to all children enrolled in non-Medicaid SCHIP programs. Finally, the prohibition against partial benefit packages to allow states with non-Medicaid SCHIP programs to provide additional wrap-around coverage to children who have inadequate private health insurance should be eliminated.

**Conclusion**

SCHIP has a proud history on which to build. To achieve continued success in reducing uninsurance among children and ensuring access to high-quality pediatric care, the AAP recommends that Congress and state policymakers adopt these important recommendations. In closing, the American Academy of Pediatrics seeks to ensure that Congress keeps in mind the children we care for as it considers reauthorizing SCHIP. The Academy would welcome the opportunity to provide further information and input to the Committee as it engages in the SCHIP reauthorization debate.